MARYLAND MEDICAID VALUE DESCRIPTIONS

Field Name	Description	Value
Place of Service	Office	11
	Patient's Residence	12
	Inpatient Hospital	21
	Outpatient Hospital	22
	Emergency Room - Hospital	23
	Ambulatory Surgical Center	24
	Birthing Center	25
	Military Treatment Facility	26
	Skilled Nursing Facility	31
	Nursing Home	32
	Custodial Care Facility	33
	Hospice	34
	Ambulance - Land	41
	Ambulance - Air or Water	42
	Federally Qualified Health Center	50
	Inpatient Psychiatric Facility	51
	Psychiatric Facility Partial Hospitalization	52
	Community Mental Health Center	53
	Intermediate Care Facility/Mentally Retarded	54
	Residential Substance Abuse Treatment Center	55
	Psychiatric Residential Treatment Center	56
	Comprehensive Inpatient Rehabilitation Facility	61
	Comprehensive Outpatient Rehabilitation Facility	62
	End Stage Renal Disease Treatment Facility	65
	State or Local Public Health Clinic	71
	Rural Health Clinic	72
	Independent Laboratory	81
	Other Unlisted Facility	99

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ — PICA ☐☐☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS — Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO — MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO — MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

NOTHING CAN BE IN THIS AREA! MMA NEEDS THIS SPACE FOR THE INVOICE CONTROL NUMBER.

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other

CITY | STATE

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

Recipient *11 Digit* Number

Full-Time Student | Part-Time Student

MUST Be Here!

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

12345678910

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNI

SAMPLE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of to process this claim. I also request payment of government benefits either to mys below.

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR | 15. IF PA

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY

MOST COMMON PROVIDER

17. NAME OF REFERRING PH

IRRENT SERVICES MM DD YY

19. RESERVED FOR LOCAL USE

$ CHARGES

NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

SUBMISSION

ORIGINAL REF NO

BILLING ERRORS!

RIZATION NUMBER

1. 2. 3. 4.

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHY & PH

Provider *9 Digit* Number

MUST Be Here!

PIN# GRP# **123456789**

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 HCFA-1500 (12-90) FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500 APPROVED OMB-1215-0060 FORM BLKLUNG

HIPAA COMPLAINT PDN/AIDE CODES

Service	Procedure Code	Description of Code
Initial Assessment	T1001	RN up to 15 minutes
1nurse/1 recipient	T1002	RN up to 15 Minutes
1 nurse/1 recipient	T1003	LPN up to 15 minutes
1 nurse/2 recipients	T1002	RN up to 15 minutes
1 nurse/2 recipients	T1003	LPN up to 15 minutes
1 aide/1 recipient	T1004	Aide up to 15 minutes
1 aide/2 recipients		

Note: 1. Procedure codes T1002, T1003, and T1004 require preauthorization.

2. Services provided to individuals sharing a nurse must be billed with the "TT" modifier indicated. See note to field 24D.